

## MEDICAL REPORT INFORMATION FORM

All students who attend Sabancı University must provide medical information to the Health Center of Sabancı University. One of the main objectives of this application **is to enable the university to provide a safer and healthier environment for students**. The information that you fill out below, will become a part of your medical record and this record is confidential and will not be released to anyone without your permission.

**THIS FORM MUST BE COMPLETED BEFORE REGISTRATION AND MUST BE SUBMITTED DURING REGISTRATION TO HEALTH CENTER IN PERSON.** Don't forget to have a blood test done (Hemogram, HBsAg, Anti-HBs, Anti-HBc IgG, Anti-HAV IgG, Anti-Measles IgG, Anti-Mumps IgG, Anti-Rubella IgG) and get chest x-ray to fill the Medical Information form. You have to give the chest x-ray results and blood test results to the responsible person of Medical Department during the registration. (Even if you have graduated from Sabancı University)

<b>REGION INFORMATION: Please select the region you are from.</b>						
Turkey ( )						
Sub-Saharan Africa ( )		( Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo (Brazzaville), Congo (Democratic Republic) Côte d'Ivoire, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Réunion, Rwanda, Sao Tome and Principe, Senegal Seychelles, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Tanzania, Togo, Uganda, Western Sahara, Zambia, Zimbabwe )				
Other Country ( )						
<b>1.MEDICAL INFORMATION OF THE FAMILY</b>						
<b>Put a mark on the previous and current diseases of your families</b>						
DISEASES	No	Mother	Father	Sibling	Uncle/Aunt(Paternal)	Uncle/Aunt(Maternal)
Thalassemia Minor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Hemoragy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemiplegy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic Diseases (explaines)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input style="width: 100%; height: 20px;" type="text"/>						
Goitre(Swelling of the Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miyocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input style="width: 100%; height: 20px;" type="text"/>						
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others (explains)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY	ALIVE	DECEASED	REASON OF DECEASE
Mother	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Father	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

## 2.MEDICAL INFORMATION OF THE STUDENT

Put a mark on the previous and current diseases you have had.(Define the diagnosis, the date, the treatment type and your current situation.)

DISEASES	Select	Explanation
Thalassemia Minor	<input type="checkbox"/>	<input type="text"/>
Allergy (medicine)	<input type="checkbox"/>	<input type="text"/> <b>Medicine Name</b> <input type="text"/>
Food Allergy	<input type="checkbox"/>	<input type="text"/>
Pollen Allergy	<input type="checkbox"/>	<input type="text"/>
Allergy (others)	<input type="checkbox"/>	<input type="text"/>
Anemy	<input type="checkbox"/>	<input type="text"/>
Asthma Bronchiale	<input type="checkbox"/>	<input type="text"/>
Depression	<input type="checkbox"/>	<input type="text"/>
Acute Rheumatic Arthritis	<input type="checkbox"/>	<input type="text"/>
Epilepsy	<input type="checkbox"/>	<input type="text"/>
Ortopedic Handicap	<input type="checkbox"/>	<input type="text"/>
Eye Problems	<input type="checkbox"/>	<input type="text"/>
Goitre(Swelling of the Thyroid)	<input type="checkbox"/>	<input type="text"/>
Rheumatic Carditis	<input type="checkbox"/>	<input type="text"/>
Heart Diseases(others)	<input type="checkbox"/>	<input type="text"/>
Menengitis	<input type="checkbox"/>	<input type="text"/>
Migraine	<input type="checkbox"/>	<input type="text"/>
Nefritis	<input type="checkbox"/>	<input type="text"/>
Loss of Organ	<input type="checkbox"/>	<input type="text"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="text"/>
Tuberculosis	<input type="checkbox"/>	<input type="text"/>

Hypertension	<input type="checkbox"/>	
Others(explains)	<input type="checkbox"/>	

### 3.CONTINUOUS MEDICATION

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### 4.OPERATIONS

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Tonsil	<input type="checkbox"/> Others	
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### 5.STUDENT'S HEALTH INSURANCE (Only for Turkish Students)

HEALTH INSURANCE	No	SGK	Private
	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Company Name <input type="text"/>

### 6.EXAMINATION TO BE MADE and VACCINES

#### 6.1. Tbc (Tuberculosis) : (Required for all of the students)

<b>Chest X-Ray Date</b> <input type="text"/>	<b>Result</b> Normal( ) Not normal( )	Please write the date of the chest x-ray that you had in a recent year. On the enrollment day, you should give your chest x-ray and its report to the Health Center personel. (Confirmed by Tuberculosis - Fighting Clinic's doctor or Radiology/Chest Diseases expert)
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#### 6.2. For Meningococcic Meningitis : (Required for from Sub-Saharan African Students)

<b>Vaccination Date</b> <input type="text"/>	<b>Vaccine name</b> <input type="text"/>	You have to get your vaccine in your country. Indicate the date and name of vaccine;
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#### 6.3. For Hepatitis A: (Required for all of the students)

<b>Test Date</b> <input type="text"/>	<b>Anti-HAV IgG</b> Poz( ) Neg( )	If the test result is negative, you have to get first dose of Hepatitis A in your country before you come to Turkey. The second dose of the vaccine is given after six months from the first dose. You can get your 2nd dose of vaccine at the Health Center of Sabancı University.
<b>Indicate the dates of vaccine.</b> 1.Dose : <input type="text"/> 2.Dose : <input type="text"/>		

#### 6.4. For Hepatitis B: (Required for all of the students)

<b>Test Date</b> <input type="text"/>	<b>HBsAg</b> Poz( ) Neg( )	<b>Anti-HBs</b> Poz( ) Neg( ) Unit <input type="text"/>	<b>Anti-HBc IgG</b> Poz( ) Neg( )
<b>Indicate the dates of vaccine.</b> 1.Dose : <input type="text"/> 2.Dose : <input type="text"/> 3.Dose : <input type="text"/>			If all the test results are negative, you can get your Hepatitis B vaccine in your country or at the Health Center of Sabancı University.

#### 6.5. For Measles (Rubeola), Rubella and Mumps: : (Required for all of the students)

<b>Test Date</b> <input type="text"/>	<b>Anti-Measles IgG</b> Poz( ) Neg( )	<b>Anti-Mumps IgG</b> Poz( ) Neg( )	<b>Anti-Rubella IgG</b> Poz( ) Neg( )
<b>Vaccine Date :</b> <input type="text"/>	<b>Vaccine Name:</b> <input type="text"/>	If one of these three tests is negative, you have to get MMR vaccine. Indicate the date and name of vaccine.	

#### 6.6. HEMOGRAM (complete blood count) - INSPECTION DATE : / / 2014 (dd/mm/yyyy)

Erythrocyte (Red Blood Cell)(RBC)	<input type="text"/> mil/uL	Hemoglobin (Hb)	<input type="text"/> g/dL
Hematocrit (Hct)	<input type="text"/> %	Leukocyte (White Blood Cell)(WBC)	<input type="text"/> bin/uL
Thrombocyt (Platelet)(Plt)	<input type="text"/> bin/uL	MCV	<input type="text"/> $\mu$ m <sup>3</sup>
<b>7.OTHERS INFORMATION</b>			
Do you smoke?	<input type="radio"/> <b>Yes</b> <input type="text"/> unit/day <input type="text"/> since year		<input type="radio"/> <b>No</b>
Height	<input type="text"/> cm	Weight	<input type="text"/> kg

**For Questions :**

Health Center

Contact : 0 216 483 99 23

healthcenter@sabanciuniv.edu